

Parents with mental illness: (re)negotiating social roles, balancing
responsibilities and managing risk

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ABSTRACT

This Master's thesis consists of two parts. The first is a literature review and reflection on the research process. The other part is a scientific article (Jones, M., Pietilä, I., Joronen, K., Simpson, W., Gray, S. & Kaunonen, M.: The varied voices of parents with mental illness – a discourse analysis of focus group discussions).

In the literature review the main themes of the study are discussed in more depth. These include mental illness and the ways in which it is portrayed and perceived in society; experiences of stigma; ideas of 'good' parenting and the emphasis social and health care services place on risk and risk management. Much of the previous research regarding parental mental illness focuses on the intergenerational transmission of illness and potential consequences of illness on children. Parental interpretations and experiences have not been as widely studied. Stigma and the fear of stigma can limit the willingness for parents to share information. There are also no requirements for mental health services to gather information on the parenting status of service users which can also limit the support families receive.

The article aims to explore the interpretations parents with mental illness have of the dominant discourses, which tend to focus on their deficits. The data was gathered through focus group interviews conducted in Finland and Scotland, with 19 participants. Methods of critical discourse analysis were used in data analysis and four larger themes identified from the data are explored in more depth.

The study discusses some of the challenges parents with mental illness can face, but also the ways in which they attempt to manage difficult situations and remain responsible parents to their children.

Key words: mental illness, parenting, qualitative, risk, expert by experience, stigma

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1 INTRODUCTION

This study focuses on parents with mental illness, examining their relationship to and interpretations of discourses on mental illness, parenting and risk. Parents and parenting with mental illness have been researched prior to this. However, the main emphasis has been placed on intergenerational transmission of illness and the potential deficits in parenting skills. Parents themselves have not been the primary focus of many studies on parental mental illness, but their abilities to parent have often been placed under scrutiny. In this study interview materials gathered in Finland and Scotland are analysed and hence the literature review will place emphasis on the social context of these countries.

In the UK, it has been estimated that one in four adults experience mental illness in any one year (Singleton, Bumpstead, O'Brien, Lee, & Meltzer, 2001), and more than half of the mental health service users are parents (Royal College of Psychiatrists, 2014). In Finland approximately 20-25% of adults have experienced mental illness (Lönnqvist, Henriksson, Marttunen, & Partonen, 2011), and one in three of those receiving psychiatric care have children (Leijala et al., 2001). However, it is difficult to attain exact numbers of service users who are parents, as this information is not consistently collected in either country (Fowler, Robinson, & Scott, 2009).

Parents with mental illness can experience stigma due to having a diagnosis associated with negative stereotypes (McDaid, 2008). People who suffer from mental health problems still remain one of the most excluded groups in society (Department of Health, 2006). The parenting experiences with both joys and challenges are similar with parents who have mental illness and those who do not (Nicholson, Biebel, Hinden, Henry, & Stier, 2001). However, parents with mental illness need to negotiate their parenting role in relation to the issues of stigma, negative stereotypes and questions regarding their abilities to be 'good' parents. These aforementioned themes will be discussed in the literature review and explored further in the analysis of the interview data.

The concept of risk is a recurring theme throughout this study. As a term its meaning can vary depending on who is using it. Douglas (1992) has suggested that the meaning of risk has changed in contemporary western society from a neutral term into being

synonymous with danger. Lupton (2005) has argued that a “discourse of risk” has developed in relation to health issues, leading to individuals and groups being labelled as being at risk. This relates to the themes of this study in several ways, as perceptions and portrayals of mental illness are often closely linked with ideas of posing a risk to self and others. Parental mental illness is seen as a risk to the children and potentially compromising the ability to parent. Parenting with mental illness is also frequently viewed from a risk perspective by health and social care services.

The thesis consists of two parts, first of which is a literature review and the second an article manuscript (Jones, M., Pietilä, I., Joronen, K., Simpson, W., Gray, S. & Kaunonen, M.: The varied voices of parents with mental illness – a discourse analysis of focus group discussions). The literature review discusses the themes of the article in more depth and presents more information, as well as evaluation of previous research. It also briefly introduces the methodological framework used in the article.

2 LITERATURE REVIEW

2.1 Mental illness

2.1.1 Definitions

The WHO (2013) describes mental illnesses as the leading cause of disability worldwide. In Finland about one quarter of people suffer from psychological symptoms with adverse effects at some time in their lives (European Commission, 2008). In the UK, the 2007 adult psychiatric morbidity survey found that the proportion of the English population aged between 16 and 64 meeting the criteria for one common mental disorder was 17.6%, which was an increase from the previous 2003 survey (Mental Health Network, 2014). Mental illness refers to all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood or behaviour associated with distress and/or impaired functioning (Thomas, 2003). There are two major diagnostic manuals, the ICD-10 and DSM-V which set out the way in which mental illnesses are classified.

However, it should be noted that mental illness can have a wide range of different definitions. Through the medical model mental health is described as the absence of symptoms of mental illness. The societal reaction model argues that mental illness in a scientific sense does not exist, but it is a construct of society as means of controlling deviant behaviour, regarded as negative and labelled as mental illness (Thomas, 2003). Once the label is applied, the affected individual is seen in a new light by society and by himself. Permanent stigmatization may result and continue to be attached to the individual regardless of the outcome of the episode (Thomas, 2003).

In this study all the interview participants had experienced mental illness during their life and refer to their illnesses as diagnosed medical conditions. The alternative definitions, which question mental illness, are not explored further in this study as these themes were not brought up in the discussions. However, the concepts of stigma and labeling due to a mental illness diagnosis are explored in more depth.

2.1.2 Mental illness in society - media portrayals and public perceptions

Francis et al. (2001) has argued that much of the information about mental illness for professionals, politicians and lay people, comes from the media. Media presentations of people with mental illness can influence and maintain negative stereotypes and potentially contribute to the stigma associated with mental illness (Murphy, Fatoye, & Wibberley, 2013). Portrayals of mental illness are often linked to violence and/or criminality (Francis et al., 2001), constructing a message, that people with mental illness pose a significant risk (Phelan & Link, 1998). This can further enforce the notion of differentiation (Foster, 2001). These portrayals have also been criticised and challenged, but the coverage has still remained predominantly negative (Murphy et al., 2013).

In relation to public perceptions, a survey by Crisp et al. (2000) conducted in the UK found that respondents held negative views regarding people with mental illness, but the perceptions differed depending on the disorder. Schizophrenia was commonly associated with dangerousness and unpredictability, whereas people with major depression were viewed as hard to talk to and 19% of the respondents thought that they could pull themselves together (Crisp et al., 2000). Stuart (2003) found that members of the public are likely to exaggerate the strength of the relationship between major mental disorders and violence, as well as their own personal risk from the severely mentally ill. Indeed, it is far more likely that people with a serious mental illness will be the victim of violence (Stuart, 2003). In a survey conducted in England, in 2007 the number of people agreeing with the statement 'We need to adopt a far more tolerant attitude toward people with mental illness in our society' had fallen to 84% compared with 92% in 1994 (TNS, 2007).

The concept of risk is closely related to the negative perceptions of people with mental illness. They are portrayed as either a danger to themselves and in need of protection, or as a danger to others with the general public needing protection from them. These negative images have been a target of some of the anti-stigma campaigns, highlighting the commonality of mental illness is and challenging discrimination (Time to Change, 2008; Watson & Goldie, 2013). However, so far the anti-stigma campaigns have not proved to be successful in producing significant changes (Dinos, 2014).

2.1.3 Stigma and mental illness

Stigma can be described as a fluid term, which has varied in meaning over the centuries. Goffman (1963) defined stigma as an “attribute that is deeply discrediting” and that reduces the bearer “from a whole and usual person to a tainted, discounted one”. These ideas have been taken forward in the literature on the nature of prejudice and stereotypes (Byrne, 2001). Stigma can also be closely linked with blame, as the stigmatized are being held accountable for their illness, disease or injury, particularly through neoliberal ideologies focusing on personal responsibility (Scambler, 1997). Reidpath et al. (2005) have argued, that stigmatized are marked as ‘unworthy’ amid finite resources and they are at risk of being considered a drain on resources.

Smith (2013) has described stigma as a dynamic relational process, rather than a mark. It occurs in a complex mesh of relationships involving labelling, stereotyping, separation, status loss, discrimination and power imbalances (Link & Phelan, 2001). These processes occur at an individual level and in whole populations; affect some people with mental illness but not all (Smith, 2013). The process of becoming stigmatized can be linked to the human capacity to form groups, and their identities becoming underpinned by the group norms and values (Whitehead, Carlisle, Mason, Watkins, & Scambler, 2005). The groups’ descriptive rules can manifest themselves in a variety of ways, including ridicule and dismissive commentary (Whitehead et al., 2005). The function of these strategies is to establish the ‘them and us principle’ (Foucault, 1973). Once established, this strategy allows for any amount of stigmatisation and social exclusion (Whitehead et al., 2005).

There are multiple factors influencing stigma at population level, which are not yet understood, including the changes in population attitudes and opinions (Smith, 2013). Hence both understanding and tackling stigma are complex issues. There is a significant gap in the perceptions of the general public and members of stigmatised groups, with the former believing such groups receive preferential treatment, whereas the latter believe they are being discriminated against (Dinos, 2014). Anti-stigma campaigns aim to reduce stigma, but are often caught in a paradox of highlighting two opposing interpretations (Gergel, 2014). Emphasising the similarities between mental illness and ‘ordinary’ experiences can target the fear-related prejudices associated with imagined ‘otherness’, but this risks conclusions that mental illness indicates moral weakness (Gergel, 2014). On the

other hand emphasising mental illness as different from ‘normal’ experience risks responses of fear of the alien (Gergel, 2014).

2.1.4 Living with a stigmatising condition

There is variation in the extent to which stigmatising conditions, such as mental illness, are recognised, and the extent to which they affect people’s lives varies. Hence individual responses can also differ, as some seem disempowered and others energised by the experiences of stigma (Corrigan & Watson, 2002). It is also possible to experience self-stigma, which people with mental illness can turn against themselves (Corrigan & Watson, 2002). Due to self-stigma, the individual can experience diminished self-esteem/self-efficacy, righteous anger (which can lead to a drive to change their role in the health system), or relative indifference depending on the parameters of the situation (Corrigan & Watson, 2002).

To use Goffman’s (1963) terminology, some illnesses can be described as ‘discredited’ (stigma is immediately apparent) or ‘discreditable’ (stigma is only occasionally apparent). The former usually need to focus on managing tension, whereas the discreditable will need to manage information or ‘pass on as normal’ (Scambler, 1997). Many mental illnesses are cyclical in nature and symptoms which people experience can vary between individuals and change over time. Hence some the symptoms may or may not be noticeable to others. However, information management is often a commonly shared issue and will be discussed in the results section of this study.

Common themes in literature which examines experiences of people with mental disorders include social exclusion, financial hardship and discrimination (Byrne, 2001). Living with a mental illness can be challenging, not just due to the illness itself, but due how others react to their illness. A report, based on responses from UK mental health service users, shows that 70% have experienced discrimination in some form: 47% in the workplace, 44% from general practitioners and 32% from other health professionals (The Mental Health Foundation, 2000). A study commissioned by the Finnish Central Association for Mental Health (2013) found that 44 % of people with mental health problems feel stigmatised due to their illness and 28% felt that people avoided their company.

2.2 Parenting

2.2.1 Parenting and mental illness – a brief overview of previous research

A large body of literature exists, focusing on the potential consequences of parental mental illness on children. Lauritzen et al. (2015) have written about parental mental illness transmission from one generation to the next and several other studies have focused on the intergenerational transmission of illness through genetic factors. For example Beardslee et al. (1998), found that children of affectively ill parents have, by the age of 20, a 40% chance of experiencing an episode of major depression. Mattejat and Remschmidt (2008) found that while the lifetime risk of developing schizophrenia is around 1%, this risk increases tenfold if one parent has schizophrenia and can be up to 40% if both parents have the illness. Other studies have argued that children of mentally ill parents are also at higher risk of not only developing the illness which the parent has, but also mental illness in general as the risk is elevated more than fourfold over the rates if the general population (Beardslee, 2002; Beardslee, Gladstone, Wright, & Cooper, 2003).

Previous research has also emphasised how environmental and social factors can play a significant role. Children from homes with affectively ill parents are more likely to exhibit general difficulties in functioning, increased guilt, and interpersonal difficulties as well as problems with attachment (Beardslee et al., 1998). Marital difficulties, parenting problems, chronicity and severity of parental affective illness have been associated with the increased rates of disorder observed in these children (Beardslee et al., 1998). Severe parental mental illness has been described as a challenge to quality of life to a substantial number of children and adolescents (Bee, Berzins, Prymachuk, & Abel, 2013).

The research outlined above highlights the potential risks parents with mental illness pose on their children. The lived experiences of families and ways they try to manage these risks are not studied as widely, but can offer new insights and ways in which the families could be supported. So far the studies focusing on the parents themselves have found that parents worry about the impact that their mental illness may have on their children (Stallard, Norman, Huline-Dickens, Salter, & Cribb, 2004).

Women with a diagnosis of severe mental illness have articulated how important having children is to them, but also how they have struggled to obtain custody and to achieve what they regard as normal lives for themselves and their children (Oyserman, Mowbray, Meares, & Firminger, 2000). It has also been suggested that parenting can have positive and motivating effects for mothers with severe mental illness as the women had identified motherhood as a central force keeping them involved with treatment, a key outlet for expression of feelings of care and concern, and a valued, normative social role (Oyserman et al., 2000). In her study, conducted in Australia, Bournsnel (2007) found that parents with mental illness acknowledge that at times their illness causes disruptions on parenthood, but at the same time parenting was a positive factor which maintained their mental health.

Styron et al. (2002) have argued that the role of fathers, who have mental illness, has been underrepresented in the literature on the topic. Parenting for men with mental illness can be just as important as for women, and it can signify normalcy and respected identity (Apfel & Handel, 1993). Even when fathers with mental illness do not have custody of their children, they often wish to be reunited and think about their children's wellbeing and happiness (Apfel & Handel, 1993). Some reasons for the underrepresentation of men could be that women with mental illness are more likely to be parents than men (Nicholson, Nason, Calabresi, & Yando, 1999) and women are also more likely to assume the main caretaker role for children (Ritsher, Coursey, & Farrell, 1997). However, this bias can also be argued to occur due to a larger societal bias, which supports the role of women as parents while ignoring or discouraging men's roles (Styron et al., 2002).

2.2.2 The 'good' parent

What is considered 'good' parenting varies in time between societies and even within societies. Warmth, nurturance and provision of developmentally appropriate and consistent supervision, structure and autonomy are often identified as hallmarks of good parenting (Oyserman et al., 2000). Parenting role carries a normative, social and developmental status which makes it central to one's sense of self and something that is considered a positive and central part of life (Oyserman et al., 2000). Parenting is portrayed as a gender neutral term but the discussions around parenting still remain largely centred around the role of the mother despite the increased role of fathers in

caring for children (Sullivan, 2010). Nevertheless, fatherhood is also an emotional, deeply meaningful and challenging experience to men (Lupton & Barclay, 1997) and should be considered as such.

There has been an increased emphasis on individual responsibility and self-management as parents are expected to be responsible for risk management and life planning of their children (Hoffman, 2010) and shaping them into responsible citizens (Lister, 2006). Intensive parenting ideology is intertwined with neoliberalism (Beck & Beck-Gernsheim, 1995). Parents are increasingly held responsible for risk management and life planning, and 'bad parenting' is thought to lead to numerous social ills, ranging from poor educational and developmental outcomes to criminality (Hoffman, 2010). Parenting itself becomes a source of risk and anxiety, as what happens is viewed as the product of individual, autonomous choices (Phoenix, 2004). Parents can be placed in competition with one another in achieving desirable child outcomes, with the social standing of parents seen as contingent on child accomplishments and intelligence (Wall, 2010).

In her study about the shifting discourses in parenting, Wall (2013) writes about the increased expectations and tasks associated with good motherhood as mothers have become more responsible for the children's psychological and emotional wellbeing. In an uncertain, risk filled climate, life is portrayed as a planning project which includes managing risks and making the 'right' choices (Wall, 2013). Hence protecting children from risk and maximising their potential becomes part of a project of what has been referred to as middle class parenting (Wall, 2013). In addition Furedi (2008) has claimed that what is regarded as 'acceptable' risk in terms of the safety of children has decreased in recent years. It has been argued that parents, particularly those who do not meet the middle class ideals, are positioned as a risk to their children (Lee, Macvarish, & Bristow, 2010).

2.3 Perspectives and frameworks of health and social care services

2.3.1 Families remaining unnoticed

A study by Bournsnel (2007), focusing on parents with mental illness, highlighted how mental health services in Australia do not collect information on the parenting status of service users. Bournsnel (2007) saw this as a hindering factor for receiving support.

There is no routine identification or assessment of mental health service users as parents in the countries this study is focusing on either (Fowler et al., 2009). The Social Exclusion Unit (2004), in their Mental Health and Social Exclusion Action Plan, identified parents with mental health problems and their children as one of four groups most likely to face barriers to getting their health and social care needs addressed. Based on a recent Ofsted (2013) report a recommendation was made to the UK government, that information about children would be systematically collected, as currently many families have to go without support. There may also be other barriers to parents getting support, as a study conducted among adult mental health nurses found, that they needed to over rely on child mental health services for support on parenting issues as there is no system in place to collaborate with other agencies to address parenting issues (Thompson & Fudge, 2005).

On the other hand, there has been an overall policy shift towards a more family oriented approach and an increased emphasis to support parents in their parenting role (Social Care Institute for Clinical Excellence, 2011). However, lack of information and collaboration may still be limiting the support parents are offered. Despite increased efforts to find out more about the social circumstances of adult mental health service users, the staff members working in adult mental health services are in many cases unaware that service users are parents, and during periods of hospital stay children are often not able to visit (Cowling, Luk, & Mileskin, 2004; Hawes & Cottrell, 1999; Howard, 2000).

Despite numerous studies emphasising the need for collaboration, it is still in many cases inadequate or even nonexistent (Heino, 2009). Fear of stigma or judgement can play a part in the relationship between those diagnosed with mental illness and health care professionals. (Alakus, Conwell, Gilbert, Buist, & Castle, 2007) have shown that fear of children being taken away is common among parents with mental illness. This can potentially be influencing the parent's decision to disclose information about their family status to professional.

2.3.2 Service perspective - viewing parenting through risk

The relationship parents with mental illness have with health and social care services can be complex. On one hand, health and social care professionals can deliver support

and resources during difficult times. On the other hand, the parent needs to allow a level of surveillance and assessment of the family in order to access support. Risk assessment and risk management have become dominant in the delivery of contemporary mental health services and are often taken for granted and viewed as unavoidable aspects in practice (Crowe & Carlyle, 2003). This has led to social concerns potentially being placed over clinical judgement, and in the mental health care setting this can lead to attempts to control the actions and behaviours of service users and clinicians to best meet the fiscal needs of the organization (Crowe & Carlyle, 2003). Similar developments have been noted in the field of social work, where risk has become a major preoccupation, which is also reflected in the increase of written material on the topic (Stalker, 2013).

The association between risks and mental disorder has a long history dating back to the establishment of clinics and hospitals in the 19th century which separated those classed as mentally disordered from the rest of society (Crowe & Carlyle, 2003). In a clinical context risk assessment and management have become a major consideration in service delivery and largely driven by political imperatives (Crowe & Carlyle, 2003). The risk itself is situated with the person diagnosed as mentally disordered, but because that person is already regarded as socially deviant, the blame is placed on individual clinicians who have a social responsibility of ensuring public safety (Crowe & Carlyle, 2003). As the burden is placed on individual practitioners, their work can potentially become increasingly stressful and the role of assessing potential risks becomes dominant in their practice. Stalker (2013) has pointed out the lack of service user views in the literature although their role in taking managing risk on an everyday basis should not be overlooked. If mental health services operate with standardised measures, they also fail to take into account individual circumstances and acknowledge the strengths families have (Bland, Renouf, Tullgren, & Bland, 2009).

2.3.3 Parental perspectives on services

Studies conducted with parents who have mental illness, have indicated that they wish to access services that could support them, but which would also value their independence and ability to care for their children (Falkov, 1998). These feelings are often intertwined with not wishing to disclose information about their illness due to stigma or fear of losing the custody of their children. As mentioned earlier, Boursnell

(2007) has discussed why parents with mental illness may appear 'invisible' to support services and due to this might not be able to access the support they require. It can be difficult to ask help with parenting, as the parent may fear that their skill will be criticised, or that their family will be separated (Stallard et al., 2004).

Alakus et al. (2007) conducted interviews with parents who had mental health problems and raised issues around interagency collaboration, which often requires improvements; need for accessible support groups; need for information and resources about mental illness. Stallard et al. (2004) highlighted how parents worry about the impact that their mental illness may have on their children. Parents admitted as in-patients have voiced concerns about unsuitable hospital visiting conditions for children (Barnardo's, 2007) as their contact with family members can become limited or even non-existent during their hospital stay. Research has emphasizes how women with a mental illness value their parenting role and how there is a need for the adult mental health system to appreciate and acknowledge this and act accordingly (Mowbray, Oyserman, Macfarlane, & Rueda-Riedle, 2001; Nicholson & Blanch, 1994; Nicholson, Sweeney, & Geller, 1998).

2.3 Describing focus groups and the method of analysis

2.4.1 Focus groups

In this study the interview data was gathered through three focus groups conducted in Finland and Scotland. In focus groups participants are set to explore a set of issues, such as views and experiences, and through this both differing assessments of issues are discussed and meanings that lie behind group assessments are revealed in an informal way (Krzyzanowski, 2008). In focus groups people are collectively making sense, negotiating and debating their experiences and beliefs (Wilkinson, 1998). As in any form of group interaction, a dynamic occurs within the group, which affects the way in the subject is discussed (Ritchie & Lewis, 2003). Interactions between the group members give rise to disagreements, affirmations and conflicts and as the group members have the opportunity to hear others' views they can modify, refine or extend their own contributions (Ritchie & Lewis, 2003). During the group discussions conducted for this study, the group participants discussed their experiences of experiencing mental illness, parenting and dealing with different support services. Focus groups allowed the participants to share and jointly discuss their experiences and construct interpretations of the interview themes.

2.4.2 Discourse analysis

Discourse analysis is underpinned by a social constructionist orientation to knowledge, which bases itself on the philosophical assumptions that multiple versions of the world are legitimate (White, 2004). Wetherell et al. (2001) offer a definition of discourse as 'human meaning making'. Discourses describe social 'reality' as well as construct it (Berger & Luckman, 1994). Discourse analysis can be described as an umbrella term as different disciplines operationalise and conceptualise it in different ways (McCloskey, 2008). For example, linguistics places the emphasis on the structure and function of words and phrases, whereas other approaches focus more on the context of the language use (McCloskey, 2008).

In this study principles of critical discourse analysis (CDA) have been applied in the analysis of the interview data. CDA takes a particular interest in the way in which text and talk produce, resist and support power, domination and social inequalities (Fairclough & Wodak, 1997). Language is regarded as social and people are viewed as participating in discourse and through their participation as reproducing discourse (Fairclough, 2003). Fairclough (1992) describes discourse as a multidimensional concept, which should be explored from three perspectives focusing on the micro, meso and macro levels, i.e. analysing the textual language, looking at the production and consumption of the text, as well as the broader societal currents. The context of the language use is seen as a crucial element (Wodak, 2000) and hence this study also takes into consideration the wider social context.

The study aims to explore how parents with mental illness position themselves in relation to dominant discourses, many of which portray people with mental illness in a negative light and place their parenting skills into question. These discourses can shape the way the participants are viewed in society and are largely shaped by actors and institutions, with little input from the people they affect. Language is seen as defining social roles available to individuals and it serves as the primary means through which they enact identities (Chandler, 2002) and by analysing their discussions the participants respond to these discourses, negotiate their own positions and produce their own interpretations.

3. REFLECTIONS ON THE RESEARCH PROCESS

I was initially interested in studying familial experiences of mental illness. This is partly due to my prior training and work experience as a mental health nurse. After some deliberation, I decided to focus on the parental experiences and through the CAMILLE project I was able to gain access to interview data from two countries.

One option would have been to compare findings and see if the cultural and social environment in Finland and the UK lead to differing experiences. However, as I was reading the data it was the similarities rather than the differences that appeared more striking. All the group discussions placed an emphasis on slightly differing issues, and sharing personal life experiences lead the discussions into different directions. Nevertheless, when discussing the relationship with their illness or the ways in which they felt society saw them due to the illness, the descriptions were very similar in both countries. Despite admitting that they experienced challenges, all of the participants wanted to be good parents and tried to accomplish that goal through varying means. Balancing the illness with parental responsibilities and societal pressures was a common theme in all the discussions.

Using secondary data collected for the project limited some of the choices available to me, as I was not able to make choices regarding the participants or methods of data collection. Focus group interviews can be a rich source of information as participants can react to each other, agree, challenge and make further questions. Through this interaction they build collective interpretations. However, in group discussions it is also possible that people do not wish to share information, e.g. for the fear of being judged. Specifially if their stories, opinions or ideas are in conflict with the group. Groups also have participants, who are more vocal and may dominate the discussion. Prior to this process, my experience analysing group discussions was limited. I was more familiar with individual interviews. I learned a lot during the analysis, but there are also things which only became clearer after the article manuscript was completed. Hence for example the analysis of group dynamics could have been taken further than it has in this work. From the beginning, I wanted to place a strong emphasis on the macro level discourses relating to the topic and they may have taken a stronger role in this study.

The entire thesis process was exiting and extremely interesting as it offered me so many opportunities to learn and attempt new things. At the same times it taught me how much more I need to learn and allowed me to reflect on my own weaker points. The thoughtful feedback I received from my supervisors throughout the writing process was extremely helpful as they offered me among many things new perspectives and encouragement.

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